

GEORGIA CHILD FATALITY REVIEW PANEL

**Annual Report
Executive Summary
Calendar Year 2004**



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Preface

Collaboration has become a common “buzz word” among human service professionals. State organizations strongly encourage those at the local level to collaborate, stressing the benefits of working together for the common good of children and families.

However, we at the state level have often failed to follow our own advice. Too often we work in silos, and ignore or refuse to address roadblocks that impede quality services to those we assist. The good news is that recent initiatives in the state have been instrumental in fostering collaboration among state organizations.

One such initiative is the First Lady’s Children’s Cabinet. Mrs. Perdue has successfully convened top-level state executives to consider policies and procedures, as well as gaps in services that yield negative results for children. The outcome of this state collaborative has been positive changes for children. An example is the partnership between DFCS and the State Superintendent of Education’s office to ensure prompt school enrollment of foster children. Rules that required paperwork from a previous school district prior to allowing a child enrollment in a new school district were relaxed to prevent interruptions in the education of children.

Another successful effort by the Cabinet was the creation of a summer job program for foster children that included the cooperation of a number of public and private organizations. Young people gained valuable job skills they might otherwise not have had. These efforts are preventive in nature in that they serve to provide meaningful structure and supervision for children and youth, thus deterring involvement in risky behaviors.

Commissioner B. J. Walker has been a catalyst for another collaboration that is proving to be very beneficial for the Office of Child Fatality Review. Public Health, led by Dr. Stuart Brown, has partnered with the Office to provide the expertise of public health staff in aggregating and analyzing data for the Panel’s annual report. This year, Public Health has assisted in writing the report, and is responsible for its new layout. We are also currently working on an agreement with Public Health to take the lead in promoting prevention efforts at the local level based on child fatality review data.

Local child fatality review committees have proven the effectiveness of collaboration. We have proudly reported on the increase in child deaths reviewed by committees over the past two years (88% in 2002 and 95% in 2003). The percentage of child fatalities reviewed for 2004 deaths was no exception with 99% of deaths reviewed. This 99% compliance rate is a direct result of professionals on the committees working collaboratively to acquire needed information, and systematically reviewing and reporting those results. Committees are also beginning collaborations to advocate for the implementation of prevention strategies based on data generated from reviews.

Collaboration is key to prevention. Each entity involved in promoting safety and health for children must understand that this work is a continuum of care, and that no one organization can do it alone. When each one brings their strengths to the table, we’re much more likely to devise a “map” that will lead us to our desired destination - a place of safety, health, and well being for children.

Executive Summary

The Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. Information in this report details deaths that were sudden, unexplained and/or unexpected. This information is compiled from reports submitted by local child fatality review committees. The Panel is charged with tracking the numbers and causes of child deaths as well as identifying and recommending prevention strategies that could reduce the number of child deaths.

Key Findings

In 2004, 1,760 children died in Georgia. Based on death certificate data, 569 deaths were eligible for review. Child fatality review committees reviewed 564 (99%) of those deaths; however, the cause of death listed on death certificates and the cause of death determined by child fatality review committees sometimes differed due to cause of death coding standards for the death certificate data.

FATAL CHILD ABUSE/NEGLECT

Department of Family and Children Services reported that 99 children in Georgia died as a result of substantiated abuse or neglect. Those deaths were investigated by DFCS, and did not include deaths handled by law enforcement and the courts without DFCS involvement.

Child fatality review committees determined that 166 child deaths resulted from both confirmed and suspected abuse/neglect (90 confirmed and 76 suspected). The perpetrators and their relationship to the child were identified in 112 of the 166 abuse/neglect related deaths. Sixty-one percent (61%) of those perpetrators were natural parents. Homicide was the cause of 40 confirmed abuse deaths, and children under the age of 5 accounted for 88% (35) of those homicides.

NATURAL

Death certificate data indicated a total of 1,325 children under the age of 18 died of natural causes (including SIDS). Infants accounted for the vast majority (1,102) of natural deaths, and leading causes continued to be congenital anomalies, low birth weight, and premature birth. There were 130 SIDS deaths, a 21% increase from the previous year.

Child fatality review committees reviewed 212 deaths from natural causes. One hundred forty-two (142) of those deaths were SIDS/SUID. (SUID – Sudden Unexplained Infant Death - is a term used for a death that appears to be SIDS, but has other factors that could have contributed to the death.) Committees are required to review all SIDS deaths, and medical deaths that are unexpected or unattended by a physician.

INJURIES

Death certificate data listed 410 deaths to have resulted from known injuries, but 4 of those deaths listed an unknown intent. An additional 25 deaths listed an unknown cause.

Unintentional Injuries

Death certificate data indicated that 61% (354) of deaths in children ages 1 – 17 resulted from injuries (infant deaths [1,178] were mostly due to natural causes [1,102]). Seventy-six percent (76%) of all injuries in the 1 – 17 year age group resulting in death were unintentional (excludes unknown intent and unknown cause). The 3 leading single causes of unintentional injury related deaths in all age groups were:

- 150 motor vehicle incidents
- 39 drowning incidents
- 34 fire/burn incidents

There was a decrease in the number of all deaths caused by unintentional injuries (from 336 to 307) from the previous year. The most marked increase in unintentional deaths from 2003 was fire (25 in 2003 to 34 in 2004).

Child fatality review committees reviewed 322 deaths attributed to unintentional injuries. Child fatality review and death certificate data agreed on the 3 leading causes of death related to unintentional injury, but differed slightly on the number of deaths for each cause as seen below:

- 178 motor vehicle incidents
- 47 drowning incidents
- 40 fire/burn related incidents

Intentional Injuries

Death certificate data indicated 99 children died from injuries intentionally inflicted by themselves or by others. In 2004, there were 75 homicides (a 6% increase from 2003), and 24 suicides (a 4% decrease).

Child fatality review committees reviewed 100 deaths from intentional causes – 74 homicides and 26 suicides. Committees determined additional deaths to have resulted from suicide that were not identified as such on death certificates.

FIREARM DEATHS

Death certificate data indicated firearms were used in 43 child deaths. Thirty-one (31) of those deaths were ruled homicides, 8 were suicides, and the remaining 4 were unintentional.

Child fatality review committees reviewed 44 firearm related deaths. Eighty-two percent (82%) were intentional (27 homicides and 9 suicides). The type of firearm was identified in all 44 of the reviewed firearm related deaths. Handguns were most frequently used (32 of the 44).

UNKNOWN DEATHS

Death certificate data identified 25 infant and child deaths with an “unknown” cause. Child fatality review committees reviewed 23 of those 25 deaths and assigned “unknown” causes to only 7 of the 23

reviewed. They determined the remaining 16 deaths to be drowning (2), medical (4), SIDS (4), and SUID (6).

Child fatality review committees identified 14 deaths for which they were unable to determine a cause of death. Seven (7) of those deaths are referenced above. One reviewed death did not have a DC link. Death certificate causes for the remaining 6 deaths were medical (4) and SIDS (2).

PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in all 650 child deaths reviewed. Child fatality review committees determined that 84% (544) of the reviewed child deaths were definitely or possibly preventable. Ninety-six percent (96%) of all reviewed child abuse/neglect related deaths were determined to be definitely or possibly preventable.

AGENCY INVOLVEMENT

Child fatality review committees reported that in 108 (65%) of the 166 child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees identified 10 deaths for which they concluded an agency intervention could have prevented the death. Seven (7) of those 10 deaths had an abuse/neglect finding.



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